The assignment/enrollment process is conducted in consideration of service area; PCP restrictions, as applicable; and allowances for exemption from participation in PCCM for members based on specific health care needs.

2. As part of the state's discussion on the default enrollment process, include the following items:

   a. the time frame for recipients to choose a health plan before being auto-assigned;

      The member has twenty-eight (28) calendar days to complete the enrollment process. Prior to the end of the twenty-eight (28) calendar days, the member must complete and return the provider choice form by mail or call the Health Benefits Advisor to enroll by phone. The member must also, as a part of the enrollment process, provide the names of three providers (in order of preference) as choices for a PCP. In the event a member does not elect a provider, a Primary Care Case Management PCP is selected for the member, as described in (B) (1) above.

   b. the state's process for notifying Medicaid recipients of their auto-assignment;

      The member is notified of the auto-assignment by mail. An identification card is sent to the member, along with other member informational materials.

   c. the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment;

      The HBA is responsible for notifying all individuals at the time of enrollment of their right to disenroll within 90 calendar days of a PCP selection without cause.

   d. a description of the default assignment algorithm used for auto-assignment, and

      Please see above.

   e. how the state will monitor any changes in the rate of default assignment

      The State tracks the number of PCP transfers each month due to auto assignment.

C. STATE ASSURANCES ON THE ENROLLMENT PROCESS

1. The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

   The State asserts that the enrollment system allows for MaineCare members already enrolled in primary care case management to continue their enrollment in the event a PCCM does not have capacity to accept all who are seeking enrollment in primary care case management.

2. The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 412.62 (f)(1)(ii).

   X The state plan program applies the rural exception to choice requirements of 42 CFR 438.52 (a) for MCOs and PCCMs. (Place check mark to indicate state's affirmation.)

3. The state limits enrollment into a single HIO, if and only if the HIO is one of the entities described in section 1932 (a)(3) (C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)
   N/A

4. X The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56 (g) if recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less. (Place check mark to indicate state's affirmation.)

D. DISENROLLMENT

1. The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56 (c).

   MaineCare members enrolled in primary care case management may elect to disenroll with their PCP within 90 calendar days of a PCP selection without cause and at any time for good cause. Good cause is defined as a documented situation in which there is an inability, after reasonable effort, to establish or maintain a satisfactory member/PCP relationship.

2. What are the additional circumstances of "cause" for disenrollment? (If any.)

   The State may also disenroll a MaineCare member enrolled in primary care case management from a PCP panel for, but not limited to, the following reasons:

   a. contract with the PCP is terminated;

   b. a PCP dies, retires, closes his/her practice or leaves the area;

   c. member loses MaineCare eligibility;

   d. member moves to an area in which the primary care provider is no longer located within 30 minutes of the member;

   e. member's eligibility changes to a category of assistance that is excluded from participation;

f. member's status changes such that he/she meets criteria for exclusion from participation; or

g. other situations as determined appropriate by the State.

A PCP may request disenrollment of a member from his/her panel for the reasons noted below. The State must approve a PCP request for disenrollment of a member.

a. the member is in the process of being formally discharged or was previously formally discharged;

b. there is a pending lawsuit between the member and the PCP or there was a past lawsuit;

c. there is good cause, as approved by the State. Good cause is defined as a documented situation in which there is an inability, after reasonable effort, to establish or maintain a satisfactory PCP/member relationship; or

d. other situations as determined appropriate by the State.

VI. INFORMATION REQUIREMENTS FOR BENEFICIARIES

The state assures that its plan is in compliance with 42 CFR 438.10 (i) for information requirements specific to MCOs and PCCM programs operated under section 1932 (a)(1)(A) state plan amendments.

The State asserts compliance with provisions of 42 CFR 438.10 (i) and provides the following clarification regarding provisions contained in 438.10 (i)(2) (iii) related to information required in comparative, chart-like format.

Upon enrollment, all MaineCare members (including members participating in primary care case management) are provided with a handbook containing alisting of covered/non-covered services and applicable cost-sharing information. Further, all MaineCare members receive all MaineCare covered services regardless of service delivery system and geographic location. Therefore, a comparative chart is unnecessary as members enrolled in primary care case management may access the same services as those receiving benefits through the fee-for-service system, regardless of their PCP and location.

VII. DESCRIPTION OF EXCLUDED SERVICES FOR EACH MODEL (MCO & PCCM)

MaineCare Benefits Not Managed By PCPs

The following services defined in Chapter II of the MaineCare Benefits Manual, are excluded services, i.e., not managed by the member's PCP. These services do not require a PCP referral in order to be payable by MaineCare.

1. Ambulance Services, Section 5.

2. Community Support Services, Section 17.

3. Consumer Directed Attendant Services, Section 12.

4. Day Habilitation Services for Persons with Mental Retardation, Section 24.

5. Day Health Services, Section 26.

6. Day Treatment Services, Section 41.

7. Dental Services, Section 25.

8. Early Intervention Services, Section 27.

9. Family Planning Agency Services, Section 30/ Family Planning Services.

10. Home Based Mental Health Services, Section 37.

11. Home and Community Benefits for the Elderly and for Adults with Disabilities, Section 19.

12. Home and Community Based Waiver Services for Persons with Mental Retardation, Section 21 (or its successor, Chapter II, Section 21, Home and Community Benefit for Members with Mental Retardation).

13. Home and Community Based Waiver Services for the Physically Disabled, Section 22 (or its successor, Chapter II, Section 22, Home and Community Benefit for Adults with Physical Disabilities (Consumer Directed)).

14. Hospice Services, Section 43.

15. ICF-MR Services, Section 50.

16. Laboratory Services, Section 55.

17. Licensed Clinical Social Worker Services, Section 58.

18. Medical Imaging Services, Section 101.

19. Mental Health Clinic Services, Section 65.

20. Genetic Testing and Clinical Genetic Services, Section 62.

21. Nursing Facility Services, Section 67.

22. Optician Services, Section 70

23. Organ Transplant Services, Sections 45 and 90.

24. Pharmacy Services, Section 80.

25. Private Duty Nursing and Personal Care Services, Section 96.

26. Private Non-Medical Institution Services, Section 97.

27. Psychiatric Facility Services, Section 46.

28. Psychological Services, Section 100.

29. Rehabilitative Services, Section 102.

30. Substance Abuse Treatment Services, Section 111.

31. Targeted Case Management Services, Section 13.

32. Transportation Services, Section 113.

33. V.D. Screening Clinic Services, Section 150.

34. School-Based Rehabilitation Services, Section 104.

35. Additional services:

    a. Annual gynecological examinations, that may include, but are not limited to: pelvic examination, PAP smear, clinical breast examination, mammogram, CBC and routine urinalysis;
    b. Medical care provided in school-based health centers or well child clinics;
    c. Obstetrical services. Members may self-refer for obstetrical services for the duration of pregnancy, and up to sixty calendar days postpartum. At sixty calendar days postpartum, the member's PCP resumes treatment/management of member's care; and
    d. Annual, routine eye examinations provided by optometrists or ophthalmologists.

VIII. SANCTIONS

Describe how the program will implement Subpart I of 42 CFR 438 and monitor for violations that involve the actions and failures in this subpart to acts specific in this subpart (42 CFR 438.726 (a)).

Primary care case management providers are prohibited from distributing marketing materials without prior State approval and the materials may not contain false or materially misleading information.

In the event a primary care case management provider fails to carry out substantive terms of his/her agreement with the State or fails to comply with applicable requirements of sections 1932 and 1905 (t) of the Act, the State reserves the right to terminate the agreement with the provider immediately, by giving written notice to the provider.

The provider will be afforded the opportunity for an appeal prior to the effective date of termination. The State reserves the right to complete transfer of primary care case management members to a new provider prior to determination of the appeal.

In addition to surveillance and utilization review activities conducted for all MaineCare providers, the following monitoring activities are conducted for primary care case management providers:

The monitoring activities include, but are not limited to:

1. ensuring maintenance of a toll free telephone number to receive member/PCP inquiries and/or complaints;

2. monitoring PCPs' twenty-four (24) hour access telephone numbers through random calls to PCPs during regular and after office hours;

3. tracking PCP disenrollment/transfer patterns and the reasons for those disenrollments/transfers;

4. reviewing medical records in response to complaints or significant changes in utilization patterns; and

5. generating periodic utilization reports for each PCP. These reports will include, at a minimum, aggregate data on the utilization and cost experience for each PCP panel for both managed services and for those MaineCare services that are exempt. Reports will also facilitate the comparison of cost and utilization experience between panels.

In addition to the monitoring activities above, which are specifically targeted to PCPs, the State receives monthly management reports provided by the health benefits advisor in order to monitor program-wide activities. The reports enable the State to respond to issues of concern in a timely manner and enact changes through process or policy, as needed. Information includes, but is not limited to:

1. telephone summary activity (#/rate, length, incoming call reasons, language line activity);

2. eligibility & enrollment/disenrollment/exemption/auto-assignment patterns; and

3. languages spoken by casehead and number of caseheads using each language.